

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person Centered Plan (PCP)

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State
- Licensed practical or vocational nurse, acting within the scope of practice under State law
- Licensed physician (M.D. or D.O)
- Case Manager (qualifications specified in Appendix C-1/C-3)
- Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker

Specify qualifications:

- Other

Specify the individuals and their qualifications:

The Independent Service Coordination (ISC) agency. The ISC's are Qualified Intellectual Disabilities Professionals. Per contractual agreement with the OA, the ISCs are prohibited from providing direct service to waiver participants.

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- b. **Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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- c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Upon enrollment and annually thereafter each participant is given a statement of rights by the ISC. The statement of rights can be found at: <http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1201.pdf>. The rights

statement is consistent with the final Medicaid Home and Community Based Services rules CMS 2249F and 2296F.

The participant, the participant's family or legal representative, other individuals from the participant's support network as the participant, his or her family or guardian chooses, and the ISC work together to develop the plan. Direct service providers do not play a direct role in the development of the plan, nor do they attend any planning meetings, unless the participant or his or her legal representative requests their participation. Progress notes and other documentation from current providers will be used to inform planning activities.

The ISC provides information and support to enable the participant and his or her family or guardian to participate in and direct the planning process. The participant is informed of the types of services provided under the Waiver, as well as options of all willing and qualified providers. The options discussed and the choices made are documented as part of the planning process.

The plan itself and discussion of the plan is in plain language and in a manner accessible to the participant. The written plan may be produced in other formats, such as pictures, DVD, etc., to accommodate specific needs of the participant; however, the plan must exist in written format. The participant, his or her legal representative, if applicable, and the ISC all sign the plan. Providers responsible for the plan's implementation must also sign the plan.

The participant, his or her legal representative, if applicable, and direct service providers responsible for the plan's implementation are given a written copy of the plan by the ISSA when it is developed and updated. The participant and his or her legal guardian, if applicable, may also obtain a new copy of the plan by requesting it of the ISSA. Potential providers are given copies of the plan with the consent of the individual and his or her legal representative.

Annually the participant is informed about the process to request updates to the service plan and is informed of his/her right to request a revision to the service plan at any time.

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- d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The ISC agency completes the plan with the participant, the participant's family and/or legal guardian, and other individuals from the participant's support network as the family or guardian chooses. The ISC agency may not provide any direct services in order to avoid a conflict of interest.

The plan is completed prior to initial service implementation and updated at least annually thereafter. The plan may be updated more frequently should the participant's needs and circumstances change. The time and location of the assessment and person centered plan meetings are convenient to the Waiver participant and guardian.

To begin the person center planning process, ISC's complete an assessment with the participant using a standard assessment tool developed by the OA with stakeholder input. The assessment collects and compiles information about the participant's strengths, needs, preferences, desired outcomes, health, and risk factors. The tool guides an interview with the participant. Topics covered include the participant's self-description, communication needs, relationships, living arrangements, work, abilities, health/medication issues, recreation, and community connections. The assessment tool is available upon request from the OA.

The use of the statewide, standardized assessment tool ensures information regarding the participant's goals, needs, and preferences are collected and compiled. The plan must then be based on and address the assessed needs,

preferences, and desired outcomes. Next best options may be considered as responsive if the participant and family cannot specifically have what the participant and family prefer due to limitations identified.

Upon enrollment and at least annually thereafter, during the planning process, the ISC explains to the participant the types of services available under the Waiver, as well as all willing and qualified providers of services. The ISC is responsible for informing participants that a listing of all qualified providers by type of provider is available on the OA's website. A written copy of the listing may be made available by the ISSA for those participants without internet access upon request. In addition, the Operating Agency maintains a video for participants and families regarding options within the developmental disabilities system. It is available on the Operating Agency's website at <http://www.dhs.state.il.us/page.aspx?item=87154>.

The ISC is responsible for implementing the plan and monitoring its on-going implementation and effectiveness. The ISC is charged with coordinating the various services chosen by the participant, including State Plan services for healthcare and medical needs, as well as generic supports. The ISC is responsible for ensuring that providers are identified and linked for any services identified that the participant may require beyond those authorized in the Waiver, i.e. medical services, non-emergency transportation to medical appointments, dental services, optometric services, etc. The ISC must then monitor that the services are delivered as specified in the plan.

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- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

As part of the planning process with the participant and guardian (if one has been appointed), the ISC is required to assess the potential risks to the health, welfare and safety of the participant. Guidelines on the minimum components of the risk assessment are contained in the Waiver Manual. The Waiver Manual is posted on the OA website and copies are available upon request.

The risk domains that must be assessed are: health/medical, safety (home), safety (community), safety (workplace), finances, behavioral and supports.

Strategies to mitigate risk must be incorporated into the person centered plan, including the consequences of choices that may involve risk, documenting the issues concerned and the decisions made. The team will describe, when it is necessary to do so, to the participant and the participant's support network, how the preferences might be limited because of imminent significant danger to the participant's health, safety, or welfare based on the following:

- The participant's or guardian's, if one has been appointed, history of decision-making and ability to learn from the natural negative consequences of decision-making;
- The possible long and short-term consequences that might result to the participant if the participant makes a poor decision;
- The possible long and short-term effects that might result to the participant if the provider limits or prohibits the participant or guardian from making a choice; and
- The safeguards available to protect the participant's safety and rights in each context of choices.

ISC's are free to select a commercially available assessment that includes an evaluation of risk or develop their own localized assessment-as long as the assessment includes the domains listed above and the minimum components described in the Waiver manual. Assessments must be performed at least annually or more frequently if indicated by the needs of the participant. When conducting risk assessments and making recommendations to mitigate risks, assessors should:

- Gather information from a variety of sources including the individual participant, guardian, family members, paid staff, record review, observation, and assessor direct knowledge of the individual.
- Recognize that some domains may not be applicable for all individuals. In such cases, the assessor should include a brief explanation of why the domain is not applicable and, therefore, no risks are evident.
- Provide narrative information (including brief overview of current skills as well as potential and known risks) sufficient to guide the interdisciplinary team. Consideration should be given to both the risks associated with current

activities of the individual as well as potential risks which inhibit the individual from pursuing his/her goals and fully participating in integrated settings.

Backup plans are developed, if it is determined to be necessary, as part of the plan development process.

If the participant is receiving services from an agency, the agency is required to provide back-up personnel as needed. When the participant is exercising employer authority, the back-up plan is specific to the participant's needs and may include family, other social service agencies, etc.

This waiver provides support services to adults of all ages, some of who live at home with other family members. As part of the person centered planning process, the participant or guardian, if one has been appointed, can make arrangements with multiple providers who can be contacted as needed.

A back-up plan is necessary when the absence of the service presents a risk to the health, welfare and/or safety of the participant. The planning team evaluates the need and type of back-up plan taking into consideration natural supports and available waiver services. Participants residing with family members can enter into agreements with providers that can provide services in an emergency situation or provide staff substitutes when regular staff cannot work assigned hours.

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- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

A list of providers, by provider type, is available on the OA's website to assist in selecting qualified providers. A written list of providers is available upon request.

Participants are supported by the Independent Service Coordination (ISC) entity under contract with the Operating Agency. Once the individual or guardian expresses an interest in or selects the type(s) of services he or she wishes to receive, the ISC informs the individual or guardian of providers offering that type of service in the desired geographic area. ISCs will make referrals to those providers selected by the individual/guardian. These referrals must be documented on the DDPAS-10 form. The ISC ensures linkage with potential providers, and may, at the participant's request, participate in discussions or visits with providers. A copy of the DDPAS-10 form is maintained in the participant's file at the ISC entity's office.

On an ongoing basis and at least annually, the ISC, assists participants if they want to change providers. At any time, a participant may ask about other providers offering the types of services they are receiving in their geographic area. The person centered plan is updated when new providers are selected.

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- g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Annually OA staff review the adequacy of support plans through a representative sample during on-site reviews. The MA participates in select reviews. The reviews consist of record reviews, interviews with participants and staff, and direct observations.

Data from these reviews are aggregated by the OA and shared with the MA staff as part of the Waiver Quality Management Committee (QMC) meetings. This committee meets quarterly. In addition, the Medicaid Agency conducts select reviews as part of MA oversight and quality assurance.

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- h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

ISC, under contract with the OA, is specified.

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D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The ISC is responsible for monitoring person centered plan implementation and participant health and welfare. The minimum frequency of contact for monitoring the plan's implementation, including direct, in-person contact with the participant, is annually. This annual monitoring visit is in addition to the direct contact for plan development. The ISC reviews that services delivered are in accordance with the person centered plan and that all services called for in the person centered plan are being delivered.

If the ISC determines the plan is not meeting the individual's assessed needs, the ISC shall work with the participant, family and guardian, if applicable, to ensure the plan is modified as necessary. In the event that conflicts arise with providers over person centered plan issues, the ISC must assist the participant in resolving such conflicts. A resolution protocol, including time frames is posted on the OA's website at <http://www.dhs.state.il.us/page.aspx?item=56642>. The protocol includes a referral to the OA for intervention if issues cannot be resolved locally.

Upon enrollment and at least annually thereafter, during the planning process, the ISC explains to the participant what services are available under the Waiver. The ISC is responsible for informing participants that a listing of all qualified providers by type of provider is available on the OAs website. Upon request, a written copy of the listing will be provided by the ISSA for those participants without internet access upon request. In addition, the Operating Agency maintains a video for participants and families regarding options within the developmental disabilities system. It is available on the Operating Agency's website at <http://www.dhs.state.il.us/page.aspx?item=87154>.

Back-up plans are developed as part of the plan development process. Back-up plans are effective when the absence of the service presents a risk to the health, welfare and/or safety of the participant.

The ISC is responsible for implementing the plan and monitoring its on-going implementation and effectiveness. The ISC is charged with coordinating the various services chosen by the participant, including State Plan services for healthcare and medical needs, as well as generic supports. The ISC is responsible for ensuring that providers are identified and linked for any services identified that the participant may require beyond those

authorized in the Waiver, i.e. medical services, non-emergency transportation to medical appointments, dental services, optometric services, etc. The ISC must then monitor that the services are delivered as specified in the plan.

The OA monitors the ISC activity through a representative sample of participants on a continuous, on-going basis. Data is collected and analyzed as specified under the Quality Improvement sections in Appendices D and G on an on-going, continuous basis. Summary reports are shared with the MA quarterly and discussed during Quality Management Committee meetings. When problems are identified, they are documented and remediation efforts are initiated by the OA. Remediation efforts may include revising person centered plans, increased monitoring, technical assistance, plans of correction, avoidance of claims.

b. Monitoring Safeguards. Select one:

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:

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Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D1 Number and percent of satisfaction survey respondents sampled who report they receive services to address their needs. N: Number of respondents who reported they received services to address their needs. D: Total respondents sampled.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

| Responsible Party for data collection/generation <i>(check each that applies):</i> | Frequency of data collection/generation <i>(check each that applies):</i> | Sampling Approach <i>(check each that applies):</i> |
|---|--|--|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: _____ _____ | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: _____ _____ |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: _____ _____ |
| | <input type="checkbox"/> Other Specify: _____ _____ | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|--|---|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: _____ _____ | <input checked="" type="checkbox"/> Annually |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: _____ _____ |

Performance Measure:

D2 Number and percent of participants reviewed whose service plan have strategies to address all health and safety risks indicated in the assessment. N: Number of PCPs with strategies to address all identified health and safety risks. D: Total PCPs sampled with an assessed health and/or safety risk.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|--|--|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: _____ |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: _____ |
| | <input type="checkbox"/> Other Specify: _____ | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|--|---|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually |
| | |

| | |
|---|---|
| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis(check each that applies): |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: _____ |

Performance Measure:

D3 Number and percent of person centered plans reviewed that address all participant needs identified by the assessments. N: PCPs that addressed all participant needs. D: All sample PCPs reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|--|---|---|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: _____ |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: _____ |
| | <input type="checkbox"/> Other Specify: _____ | |

Data Aggregation and Analysis:

| | |
|---|---|
| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis(check each that applies): |
| | |

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|--|---|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: _____ |

Performance Measure:

D4 Number and percent of participants' OA PCPs that address all personal goals by the assessment. N: Number of OA PCPs reviewed that addressed all personal goals identified by the assessment. D: Total number of OA PCPs reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|--|--|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input checked="" type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: _____ |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: _____ |
| | <input type="checkbox"/> Other Specify: _____ | |

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Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|--|---|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: | <input checked="" type="checkbox"/> Annually |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: |

b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D5 Number and percent of PCP's reviewed that were developed in accordance with state requirements. N: Number of PCP's that were developed in accordance with state requirements. D: Total number of PCP's reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|--|--|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |

| | | |
|--|--|--|
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: _____ |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: _____ |
| | <input type="checkbox"/> Other Specify: _____ | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|--|---|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: _____ |

Performance Measure:

D6 Number and percent of PCP's where the PCP was approved by all entities within the required timeframe. N: Number of PCP's whose contents were developed in accordance with state requirements. D: Total number of PCP's reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| | |
|--|--|
| | |
|--|--|

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|--|--|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: _____ |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: _____ |
| | <input type="checkbox"/> Other Specify: _____ | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|--|---|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: _____ |

Performance Measure:

D7 Number and percent of PCP's where the PCP meeting occurred within 365 days of the previous PCP. N: Number of PCP's where the PCP meeting occurred within 365 days of the previous PCP. D: Total number of PCP's reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|--|--|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: _____ |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: _____ |
| | <input type="checkbox"/> Other Specify: _____ | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|--|---|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |

| | |
|---|--|
| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
| | <input type="checkbox"/> Other Specify: _____ |

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D8 Number and percent of waiver participants reviewed who have their Person Centered Plan updated at least annually or within 30 days of the identified change in the participants needs. N: Number of participants who have had their PCP's updated annually or within 30 days of the identified change in a participants needs. D: Number of waiver participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|--|---|--|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: _____ |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: _____ |

| | | |
|--|--|--|
| | | |
| | <input type="checkbox"/> Other Specify: | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|--|---|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: | <input checked="" type="checkbox"/> Annually |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: |

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D9 Number and percent of participants reviewed who received a minimum of one visit from the ISC entity under contract with the OA to monitor that services are being delivered in accordance with the services in the plan of care. N: Number of participants who received an ISC visit. D: Number of participants in the representative sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| | |
|--|--|
| | |
|--|--|

| Responsible Party for data collection/generation <i>(check each that applies):</i> | Frequency of data collection/generation <i>(check each that applies):</i> | Sampling Approach <i>(check each that applies):</i> |
|---|--|--|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: _____ _____ | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: _____ _____ |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: _____ _____ |
| | <input type="checkbox"/> Other Specify: _____ _____ | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|--|---|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: _____ _____ | <input checked="" type="checkbox"/> Annually |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: _____ _____ |

Performance Measure:

D10 Number and percent of participants reviewed who received the services in the scope, amount, duration and frequency as specified in their PCP. N: Number of participants who received services as specified in their PCP. D: Number of participants reviewed in sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|--|---|--|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: _____ |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: _____ |
| | <input type="checkbox"/> Other Specify: _____ | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|---|--|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually |
| | |

| | |
|---|---|
| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis(check each that applies): |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: _____ |

Performance Measure:

D11 Number and percent of satisfaction survey respondents sampled who reported the receipt of all services listed in the person centered plan. N: Number of respondents who reported receipt of all services in their PCP. D: Total number of survey respondents.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|--|---|---|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: _____ |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: _____ |
| | <input type="checkbox"/> Other Specify: _____ | |

Data Aggregation and Analysis:

| | |
|---|---|
| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis(check each that applies): |
|---|---|

| | |
|---|---|
| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis(check each that applies): |
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: _____ | <input checked="" type="checkbox"/> Annually |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: _____ |

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

D12 Number and percent of records reviewed that document participants were informed at least annually of the right to choose their providers. N: Number of participant records reviewed that document participants were informed at least annually of the right to choose their providers. D: Total number of records reviewed based on a representative sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| | | |
|--|---|---|
| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample |

| | | |
|--|--|--|
| | | Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: |
| | <input type="checkbox"/> Other Specify: | |

Data Aggregation and Analysis:

| | |
|---|--|
| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: | <input checked="" type="checkbox"/> Annually |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: |

Performance Measure:

D13 Number and percent of participants reviewed who were offered choice between/among waiver services (for which there has been a determination of need). N: Number of participants reviewed who were offered choice of waiver services. D: Total number of participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| | | |
|--|---|---|
| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
| | | |

| | | |
|--|--|--|
| <input type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly | <input type="checkbox"/> 100% Review |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly | <input checked="" type="checkbox"/> Less than 100% Review |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly | <input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% |
| <input type="checkbox"/> Other Specify: | <input checked="" type="checkbox"/> Annually | <input type="checkbox"/> Stratified Describe Group: |
| | <input checked="" type="checkbox"/> Continuously and Ongoing | <input type="checkbox"/> Other Specify: |
| | <input type="checkbox"/> Other Specify: | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|--|---|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: | <input checked="" type="checkbox"/> Annually |
| | <input checked="" type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: |

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

As required under the direction of the AA CAP, oversight will be insured by extensive review of participant service plans. There will be extensive monitoring by the contracted Quality Improvement Organization. The

QIO team will support the MA with analysis and reporting. The MA will work with the OA to ensure that waiver program service plans comply with the Person Centered Planning process. As per the direction of the AA CAP, this review activity will be updated monthly and provided to CMS.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The OA is responsible for individual remediation. A POC is submitted by the provider to the OA for approval within 14 days of notification to provider of findings that cannot be corrected immediately while the reviewers are on site. The POC must correct the findings within 60 calendar days, other than those corrected immediately while the reviewers are on site. In instances of serious findings the provider may be directed by the OA to correct a finding in a much shorter time frame, including instances of immediate correction, where appropriate. In instances where the provider fails to submit a POC or when the provider fails to submit an acceptable plan, the OA may develop and impose a mandatory POC.

Due to the nature of National Core Indicator (NCI) data being collected, no individual remediation is required for these measures. Guardian satisfaction surveys are anonymous. NCI data is a secondary data source for these measures.

The OA may impose sanctions on providers which fail to comply with conditions stipulated in the provider contract. Sanctions include, but are not limited to, payment suspension, loss of payment, and enrollment limitations, or other actions up to and including contract termination.

The OA provides summary reports of remediation activities to the MA. Staff of the MA and OA review the reports on a quarterly basis as part of the Waiver Quality Management Committee (QMC) meetings. QMC meeting summaries document findings and remediation activities.

- ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

| Responsible Party <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|---|---|
| <input checked="" type="checkbox"/> State Medicaid Agency | <input type="checkbox"/> Weekly |
| <input checked="" type="checkbox"/> Operating Agency | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Sub-State Entity | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> Annually |
| | <input type="checkbox"/> Continuously and Ongoing |
| | <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

